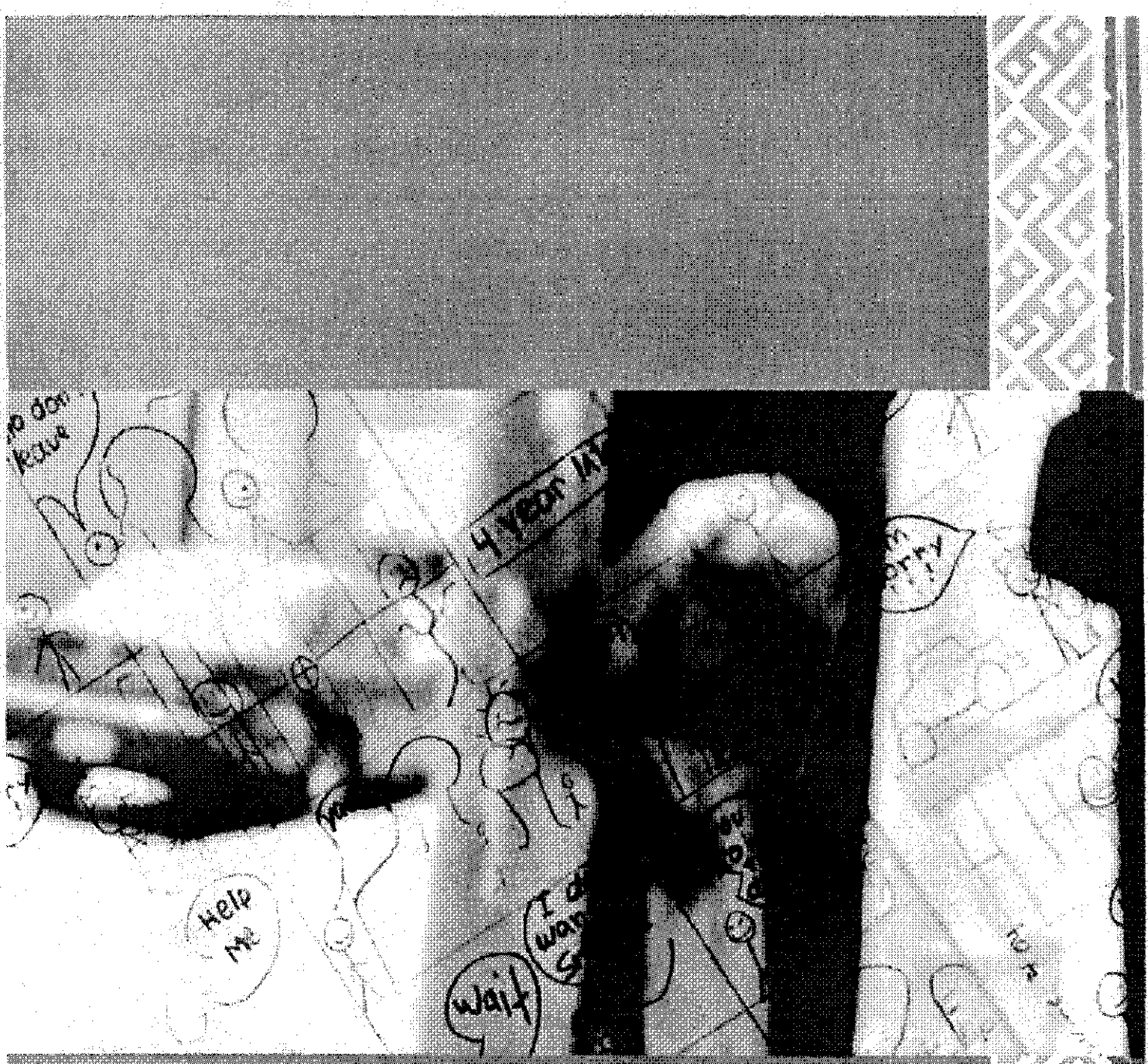

Youth Survey Findings and Recommendations • November 2005

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Report on Families With Children Living In Single Room Occupancy Hotels In San Francisco

Presented to

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City and County of San Francisco Board of Supervisors

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by

San Francisco Board of Supervisor's SRO Health and Safety Task Force and the Families in SROs Workgroup Subcommittee

May 15, 2001

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Introduction

In 1999, SRO residents and advocates organized and asserted to City leaders that critical issues facing families with children were not being addressed. The City created a "Families in SRO Workgroup" to research the issue and to recommend legislative, policy, and program changes that will help families with children:

(1) move from SROs into stable housing,
(2) be preserved while residing in SROs,
(3) live in clean, safe conditions when residing in SROs, and
(4) improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

Scope of the Problem

Although no exact figures are known, a sample survey conducted in the late 90's estimated that 500 families lived in SROs in Chinatown alone. Of the near 900 families served by the DHS family shelter placement program during the first 9 months of FY00-01, 25% identified Hotel/SROs as their prior living situation and 8% were noted as leaving to a Hotel/SRO. More comprehensive information will be available when the "Census of Families with Children Residing in SROs" is completed in July of 2001 (Attachment 1, page 42).

There are an estimated 457 SRO Hotels in San Francisco with over 16,000 residential units. When families reside in SROs, they live in the privately-owned SROs, not those operated by community based organizations. Most SROs are located in the Mission, Tenderloin, Chinatown, and South of Market and are usually situated in distressed, high crime areas within those neighborhoods. Rooms are large enough for a twin or bunk bed. Hotels do not have refrigerators, stoves, or proper storage areas to keep food. Families with children live in an 8'x10' room and for these accommodations, pay hotel owners between $250 and $500 per week.

Findings

It is a well-known fact that unstable housing has a devastating impact on a family's wellbeing, on their ability to stay intact, and the capacity of the caregiver to get and keep a job. Homeless parents use all of their paycheck, time and energy to find and maintain shelter for their families. Experts state that one month of living in the cycle of homelessness equates to one year of symptoms, including severe depression, suicidality, disturbed sleep and appetite, chronic refusal to come forward, sense of not being entitled, and emotional exhaustion.

Families get separated. It is the policy of the San Francisco Department of Human Services' Family and Children Services to not remove children from parents simply due to the fact a family is "homeless." Staff state, however, that well over 50% of their families are faced with inadequate or unstable housing, which greatly exacerbates other issues for their families.

Families live in unhealthy, unsafe environments. According to a report published by the San Francisco TB & Homelessness Task Force[53]: "Homeless shelters and SROs are among the most likely places where TB can be transmitted in San Francisco. TB incidence and census tract measures indicate high TB rates in the Tenderloin, South of Market, Chinatown and the Mission District similar to those found in Sub-Saharan Africa. One in three hotel tenants is infected with the TB germ." Families may share unclean bathrooms or be subjected to living with lead, rodents, roaches, mold, garbage and sewage, broken glass, exposed sockets, no window or stair guards, and dirty syringes. SROs are fire hazards. During the 1990s, nearly a thousand units were lost in 12 SROs to fires in San Francisco. SROs are often surrounded by liquor stores and individuals engaged in prostitution, violence, drug selling and public drug using and drunkenness.

Families are unable to meet their nutritional needs. Lack of adequate cooking, cleaning and storage space leave families dependent on fast-food outlet. Food stamps only cover about two weeks of the month's food bills. Thus the rest of the month they bridge their nutritional gaps with use of soup kitchens and emergency food pantries.

Children's physical developments are impaired. A child living in an SRO is at high risk of having:

a) Difficulty breathing due to the presence of mold, little or no ventilation, and increased triggers such as pesticides, solvents, chemical fumes, pollution, and dust mites.
b) Physical exhaustion from interrupted sleep patterns.
c) Decreased development of gross and small motor movement due to small living space.
d) Difficulty consistently taking medications.
e) Exposure to more contagion (hap) infections, spread of infection and communicable diseases due to decreased ability to clean restroom and self and high rate of exposure to second-hand smoke, needles and used condoms.
f) Increased risk for malnutrition, increased weight and obesity, Vitamin D deficiency, rickets, diabetes, hypoglycemia (low blood sugar), and hypertension due to poor nutrition and reduced activity. "Iron deficiency anemia is found to be two to three times more common in homeless children than in children who are not homeless" [25] "Deficiency anemia is a disease that is associated with behavioral problems and decreased cognitive development." [41]
g) Decreased physical development due to lack of produce and dairy.
h) Increased likelihood of urinary tract infections due to "holding going to bathroom".
i) Decreased immune systems.

"Common acute problems in homeless children include upper respiratory tract infections, scabies, lice, tooth decay, ear infections, skin infections, diaper rash, and conjunctivitis." [21] "In addition, the incidence of trauma-related injuries...and chronic disease, e.g., sinusitis, anemia, asthma, bowel dysfunction, eczema, visual deficits, and neurological deficits is notably higher for homeless children than for others." [22] "One of the preventable problems in children is injuries. In one survey of homeless mothers, 20% responded that their child needed to be seen at an ER for an injury or fall." [44]

Children's psychological developments are impaired. Even the most resilient family faces a large number of stressors in the realm of social and psychological health simply due to the environment in which they live. Lack of a stable, safe housing environment can easily lead to extreme anxiety and depression for parents. As a child lives in squalid conditions, he or she may identify with such, and feel increasingly distressed. The lack of open space and decreased personal space results in intense personification of objects and individuals with whom children share their space. They may also become disassociated from, or not aware of, space and personal space. Even such concrete developmental tasks as walking may theoretically be impeded due to lack of space. The school-age child especially needs space and facilities in which to play. The very fact that there are not sufficient facilities to do homework or to carry out appropriate grooming routines, may lead to decreased feelings of self-worth. Children living in SROs are less likely to meet normal developmental milestones. When this occurs, the child may become depressed, anxious and face an increased risk for a host of psychological and psychiatric disorders.

Children's abilities to learn and achieve are impaired. "Perhaps the most disturbing of the effects homelessness has on children are the delays in their development, like walking, talking and playing." [42] The simple lack of open space and poor nutrition result in difficulty learning, lower attention span, and poor brain development. As a result, speech, language, memory, cognition, physical dexterity and balancing are impaired. "The rate of developmental problems is two to three times higher in homeless children than in poor children who are not homeless. [24]

Families have less access to needed services. Families in SROs must "lay low", be "invisible" and not annoy hotel managers, because until they establish tenancy rights, they can be asked and forced to leave the SRO. They are often not aware of rights or entitlements available to them. It is difficult, if not impossible, for healthcare providers to reach families for follow-up care. Families in SROs are not singled-out or tracked in City Departments as they are either not identified as living in an SRO, or are not "institutionally" considered "homeless" or "at risk." "Families are so often relocating that there is no opportunity to develop an ongoing relationship with a health care provider. When there is an acute problem, hospital emergency rooms, visiting public health nurses, and clinics usually are relied on to provide episodic and fragmented care. Continuity of care is nonexistent and care is rarely comprehensive, resulting in high rates of under-immunization and other unmet health needs." [26]

Immigrant families have distinct challenges. Many families with children residing in SROs are immigrant families. If undocumented, they are automatically not eligible for

federally funded low-income housing. Immigrant families are even more at risk of the above due to language barriers, inexperience in working the "system," cultural prejudices of institutions and fear of repercussions (e.g., deportation or not being able to attain citizenship).

Recommendations

Institutionalize a continuous improvement process between departments, families living in SROs, and their advocates. The objectives would be to address the findings and recommendations for each goal outlined in this report, to routinely assess the progress made, and to continually improve the situation. These collaborations would (1) have a lead department that staffs and coordinates the workgroup, (2) adopt the goals as outlined in this report, (3) aggregate City-wide data regarding the number of homeless families, and (4) give routine status reports to City leadership and Board of Supervisors.

Goal 1: Families with children move from SROs into stable housing.

1. Assure parents residing in SROs and their advocates sit on all housing committees so that they may influence housing advocates, non-profit housing development agencies, the State of California and and the City and County of San Francisco when housing policies are being developed and to assure that they adopt child- and family-focused planning priorities.
2. Expand the number of permanent housing units planned for "very low income" families and add supportive services onsite.
3. Assure "very low income" families living in SROs can compete in the low-income housing market.
4. Develop housing policies to support economic stability and development of families.

Goal 2: Families are preserved while residing in SROs.

1. Child Protective Services collaborate with Family Resource Centers, SRO Collaboratives, SRO management and families to develop prevention policies and practices where the family is given appropriate support and intervention and the least negative impact results.
2. Develop Family Respite Programs.

Goal 3: Children live in clean, safe conditions when residing in SROs.

1. Increase responsiveness and accountability of SRO hotel owners.
2. Increase responsiveness and accountability of City inspectors, planners, and enforcement. Note: A policy change was developed with and agreed to by DPH Environmental Health Section and the Mission and Chinatown SRO Collaboratives to address chronic problems in SROs that house families with children (Attachment 3, page 44).
3. Develop and fund an SRO Collaborative for the South of Market / Tenderloin neighborhood, similar to the Mission and Chinatown Collaboratives.

Goal 4: Families with children improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

1. Standardize "homeless" definition to include families living in SROs even if they have tenancy rights.
2. Implore the public education system to respond to the distinct needs of children living SROs.
3. Educate service providers on the issues facing families living in SROs and assure that their services are family focused and responsive (Attachment 2, page 43).
4. Develop and fund multidisciplinary SRO Family Outreach Teams (including Public Health RN, Psychiatric Social Worker, Case Manager, and Peer Parent) for each neighborhood to help families with children move from SROs into stable housing and to stabilize and support families while they reside in SROs. One team should be housed in each of the three target communities: Chinatown, Tenderloin/South of Market, and Mission.
5. Other Ways City Departments can help:
   a. Provide cell phones to families
   b. Support the development of "211" line for families to utilize when homelessness and/or hunger appear eminent (Attachment 4, page 45).
   c. Relocate families in SROs together.
   d. Prioritize "homeless" families and children on waiting lists for programs offering services.
   e. Fund sufficient childcare services.
   f. Link gyms and churches to SROs.
   g. Allocate resources for Department of Recreation and Parks to open more sites.

Introduction

Background

Over the years, tenant's advocates have seen a rise in the number of families with children residing in Single Room Occupancy Hotels (SROs). Daily, they witnessed how inadequate, inappropriate and risky SROs were for families with children to live.

In 1999, SRO residents and advocates organized and asserted to City leaders that issues facing families in SROs were not being addressed by City agencies, the treatment system, the homeless advocacy community or the children's advocacy community – and that the problem was rising to a critical level.

Under the direction of the San Francisco Department of Children, Youth, and Families, three focus groups occurred where resident families and advocates outlined the problems, concerns, and needs of families residing in SROs.

In Spring of 2000, a Citywide workgroup, chaired by the Department of Public Health and comprised of advocates, residents, providers, and staff from the Mayor's Office on Homelessness, Department of Human Services, and Board of Supervisors was formed to address the issues facing families living in SROs.

The "San Francisco Families in SRO Workgroup" was then adopted as a formal subcommittee of the San Francisco Board of Supervisors' SRO Task Force (formed to deal with a wide array of SRO issues).

The goals of the Workgroup are that families with children:
(1) move from SROs into stable housing,
(2) are preserved while residing in SROs,
(3) live in clean, safe conditions when residing in SROs, and
(4) improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

The workgroup was charged with recommending legislative, policy, and program changes that will help the City achieve these goals. Over the course of 14 months, the Workgroup met monthly, conducted focus groups and research, and met with individuals in the community and in City departments to discuss and develop the findings and recommendations included in this report.

This report will be submitted to the San Francisco SRO Task Force and to City Department leadership. The SRO Task Force will incorporate this report with their summary report to the San Francisco Board of Supervisors on May 15, 2001, at a special hearing held by the "Economic Vitality, Small Business, and Social Policy" Committee of the San Francisco Board of Supervisors.

Scope of the Problem

Although no exact figures are known, a sample survey conducted in the late 90's estimated that 500 families lived in SROs in Chinatown alone.

Having served nearly 900 families in the first nine months of FY00-01, the Department of Human Service (DHS) estimates that the number of homeless families their shelter placement program will serve this fiscal year will be 20-25% greater than last year. The "wait list for shelter" currently averages 100 families at any given time.

Scope of the Problem continued

Statistics from their shelter placement program noted that "25% of families completing an intake identified 'Hotel/SRO' as their prior living situation. 34% said they had stayed in a shelter before. 8% exiting were noted as leaving to a 'Hotel/SRO.' "

Currently, the San Francisco Housing Authority has over 13,000 families waiting for a unit. The number of homeless families promises to rise with the increase of Ellis Act evictions, San Francisco's expansion of the condo conversion ordinance, and the movement to restrict Hotel Conversion violations. Also expected to increase the number of homeless families is the national changes to Housing Authority regulations, including the "one-strike" regulation, evictions subsequent to loss of subsidies to the undocumented, and the constraint of increasing the number of housing vouchers instead of housing units.

In April of 2001, the Department of Public Health funded a "Census of Families with Children Residing in SROs" project. The census is to be conducted in four neighborhoods: Mission, Chinatown, South of Market, and Tenderloin. Coordinated by the Mission SRO Collaborative, 16 SRO residents will be trained and mentored in peer outreach and advocacy. They, along with staff from nine community based organizations, will:

1. Conduct a comprehensive point-in-time count of families with children residing in 400 SROs located within each of the 4 targeted neighborhoods (The Franciscan in Bayview Hunter's Point will also be surveyed).
2. Conduct 200 in-depth interviews with randomly selected families residing in SROs throughout the 4 neighborhoods (Attachment 1, page 42). Surveyors will also provide information about tenant's rights and relevant community and government resources.

An analysis and summary report profiling families with children residing in SROs in San Francisco will be published for use by community organizations and City departments to plan, design and develop services and low income housing for this population. It is expected that the census/interviews will be completed by July 2001.

How Families are Defined

Families encompass all nationalities, races, ethnic backgrounds, genders and sexual orientations. Primary caregivers include, but are not limited to, biological parent(s), grandparents, adopted parents, legal guardians, and extended family members who have children in their immediate care. For the sake of simplicity, this document will refer to primary caregivers as "parents."

Parent(s) fall into one or more of the following categories:

a. Individual(s) who has actual custody of, and is responsible for the care of, at least one child under the age of 18,
b. a pregnant woman,
c. individual(s) in the process of securing legal custody of any person who has not attained the age of 18 years,
d. individual(s) with a dependent child over the age of 18 who is mentally or physically disabled.